DEPARTMENT OF HEALTH & HUMAN SERVICES — Office of Inspector General

Memorandum

Date: MAY 22 1996

From: June Gibbs Brown
Inspector General

Subject: Review of the California Department of Health Services Reimbursement for Clinical Laboratory Services Under the Medicaid Program (A-09-95 -OO072)

To: Bruce C. Vladeck
Administrator
Health Care Financing Administration

This memorandum is to alert you to the issuance on May 28, 1996 of our final audit report. A copy is attached.

The objective of our review was to evaluate the California Department of Health Services' (State Agency) procedures and controls over the processing of Medicaid payments to providers for clinical laboratory services to prevent overpayments for unbundled or duplicate billings. Our review included services involving chemistry, hematology, and urinalysis tests paid by the State Agency during Calendar Years (CYs) 1993 and 1994. This audit was performed as part of the Partnership Plan between Federal and State Auditors for helping control costs of the Medicaid program.

We found that the State Agency had numerous edits in place to detect provider billings that were not properly bundled. However, edits were not in place for the tests we reviewed and needed to be established. By projecting the results of our review of a random sample of laboratory billings, we estimate that the State Agency overpaid providers $8,026,980 (Federal share $4,0 13,490) for chemistry, hematology, and urinalysis tests for CYS 1993 and 1994.

We are recommending that the State Agency: (1) implement additional edits to detect and prevent payments for unbundled or duplicate laboratory services; (2) notify providers of proper billing procedures for the services identified in our audit; (3) identify and recover Medicaid overpayments from clinical laboratories for chemistry, hematology, and urinalysis services included in this review; and (4) make adjustments for the Federal share of amounts recovered, if any, on the Quarterly Report of Expenditures submitted to the Health Care Financing Administration (HCFA).

In the response to our draft report, the State Agency expressed the opinion that it was not required to follow Medicare guidelines pertaining to laboratory procedures, including those Medicare carrier guidelines governing the unbundling of laboratory tests. According to the State Agency it is guided by the published Physicians' Current

Procedural Terminology codes and its own State regulations. The State Agency listed three examples of its disagreement with our specific findings. It stated that it has no plans to make any recoveries based on the report. The State Agency did, however, agree to research the points identified in the report to determine what opportunities were available for savings that were not currently being developed and/or implemented.

States administering Federal financial participation under the Medicaid program must observe Medicare rules governing reimbursement of clinical diagnostic laboratory services, including schemes for bundling tests into automated panels. We also do not believe that the points of disagreement raised in the examples are valid. However, most importantly, the State Agency agreed to research the recommendations made in our report in order to identify future opportunities for cost savings.

Attachment

For information contact:

Lawrence Frelot
Regional Inspector General for
Audit Services, Region IX
(415) 556-5766

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF THE CALIFORNIA DEPARTMENT OF HEALTH SERVICES REIMBURSEMENT FOR CLINICAL LABORATORY SERVICES UNDER THE MEDICAID PROGRAM

JUNE GIBBS BROWN
Inspector General

MAY 1996
A-09-95-OO072

Region IX
Office of Audit Services
50 United Nations Plaza
Room 171
San Francisco, CA 94102

CIN: A-09-95 -OO072

Ms. S. Kimberly Belshe, Director
Department of Health Services
714 P Street, Room 1253
Sacramento, California 95814

Dear Ms. Belshe:

This report presents the results of our review of the California Department of Health Services (State Agency) reimbursement for clinical laboratory services under the Medicaid program.

OBJECTIVE

The objective of our review was to determine the adequacy of State Agency procedures and controls over the processing of Medicaid payments to providers for clinical laboratory services. Our review was limited to unbundling and/or duplication of clinical laboratory services involving chemistry, hematology, and urinalysis tests.

SUMMARY OF FINDINGS

The State Agency had numerous edits in place to detect provider billings to Medicaid for laboratory services that were not properly bundled. Providers are required to combine specific laboratory tests into groups billed as a single item, often called bundling. However, in our random sample of 150 instances of possible unbundled or duplicate charges for laboratory services, we found that 116 of these instances represented unbundled or duplicate charges. Based on the sample, we estimate that unbundled or duplicate charges amounted to $8,026,980 (Federal share $4,0 13,490) for chemistry, hematology, and urinalysis tests for Calendar Years (CYs) 1993 and 1994.

The 116 instances of unbundled or duplicate charges were reimbursed by the State Agency because it did not have edits to detect the following:

- unbundling of two chemistry tests,
- unbundling of Creatine Kinase (CPK) and Gamma Glutamyltransferase (GGT) tests from chemistry profiles,
- unbundling of hepatic function panels from chemistry profiles,
- unbundling of bilirubin tests from chemistry profiles,
- separate billing of hematology indices from hematology profiles,

- separate billing for more than one hematology profile or a hematology profile and hematology test, and

- unbundling or separate billing of automated or unautomated urinalysis and/or urinalysis microscopy examination from the urinalysis with microscopy service.

We are recommending that the State Agency: (1) implement additional edits to detect and prevent payments for unbundled or duplicate laboratory services; (2) notify providers of proper billing procedures for the services identified in our audit; (3) identify and recover Medicaid overpayments from clinical laboratories for chemistry, hematology, and urinalysis services included in this review; and (4) make adjustments for the Federal share of amounts recovered, if any, on the Quarterly Report of Expenditures submitted to the Health Care Financing Administration (HCFA).

In the response to the draft report, the State Agency expressed the opinion that it was not required to follow Medicare guidelines pertaining to laboratory procedures, especially those set by the local carriers. However, the State Agency agreed to research the points in our recommendations to determine what opportunities were available for savings that were not currently being developed and/or implemented. The State Agency stated that it had no plans to make any recoveries from providers based on the report.

BACKGROUND

Medicaid, authorized under title XIX of the Social Security Act, was established to pay for the cost of necessary medical services for eligible persons whose income and resources were insufficient to pay for their health care. Within broad Federal guidelines, States design, and administer the Medicaid program under the general oversight of HCFA. The State Agency is responsible for administering the Medicaid program in California. In California the Medicaid program is known as Medi-Cal.

The State Agency elected to participate in the HCFA Medicaid Statistical Information System (MSIS). States that participate in the MSIS provide two computer files, an eligibility file and a paid claims file, to HCFA quarterly. The eligibility file contains specified data for persons covered by Medicaid and the paid claims file contains adjudicated claims for medical services reimbursed under title XIX.

The HCFA State Medicaid Manual, section 6300.1 provides that Federal matching funds will not be available to the extent a State pays more for outpatient clinical laboratory tests performed by a physician, independent laboratory, or hospital than the amount Medicare recognizes for such tests. In addition, section 6300.2 states that payment for clinical laboratory tests under the Medicaid program cannot exceed the amount recognized by the Medicare program.

Under Medicare, clinical laboratory services are reimbursed at the lower of the fee schedule amount or the actual charge. Further, the carrier (the contractor that administers Medicare payments to physicians and independent laboratories) maintains the fee schedule and provides it to the State Medicaid agency in its locality. For California, there are two carriers.

Clinical laboratory services include chemistry, hematology, and urinalysis tests. Laboratory tests are performed on a patient's specimen to help physicians diagnose and treat ailments. The testing may be performed in a physician's office, in a hospital, or independent laboratory.

Chemistry tests involve the measurement of various chemical levels in the blood. Chemistry tests frequently performed on automated equipment are grouped together and reimbursed at a profile rate. Chemistry tests are also sometimes included with other tests and combined under problem-oriented classifications, referred to as organ panels. Organ panels were developed for Physicians' Current Procedural Terminology (CPT) coding purposes and are to be used when all of the component tests are performed.

Hematology tests are done to count and measure blood cells and their content. Hematology tests grouped and performed on an automated basis are classified as profiles. Automated profiles include hematology component tests such as hematocrit, hemoglobin, red and white blood cell counts, platelet count, differential white blood cell counts, and several indices. Indices are measurements and ratios calculated from the results of hematology tests.

Urinalysis involves physical, chemical, or microscopic analysis or examination of urine to measure certain components of the sample. A urinalysis may be ordered by the physician as a complete test that includes a microscopy, a urinalysis without microscopy, or the microscopy only.

Providers use the CPT codes, published by the American Medical Association, to identify the procedure or service performed. Each procedure or service is assigned a 5-digit code. These CPT codes provide a uniform language to effectively identify and bill for services rendered by a provider.

SCOPE

Our review was conducted in accordance with generally accepted government auditing standards. The objective of our review was to determine the adequacy of State Agency procedures and controls over the processing of Medicaid payments to providers for potentially unbundled or duplicated clinical laboratory services. Our review was limited to clinical laboratory services involving chemistry, hematology, and urinalysis tests paid by the State Agency during CYS 1993 and 1994.

To accomplish our objective, we:

- Reviewed State Agency policies and procedures for processing Medicaid claims from providers for clinical laboratory services.

- Extracted from California's MSIS paid claims files for CYS 1993 and 1994 payments totaling approximately $109.5 million for chemistry, hematology, and urinalysis tests. Of this amount, an estimated $26.4 million represented instances involving claims that contained potentially unbundled or duplicate charges for chemistry, hematology, and urinalysis tests.

- Tested the reliability of the computer-generated information extracted from the MSIS by comparing the data to source documents for our sampled items. We did not, however, assess the completeness of data in California's MSIS files nor did we evaluate the adequacy of the input controls.

- Performed a stratified random sample of 150 instances of possible unbundled or duplicate charges for laboratory services as follows:

	Sample Size	Universe Size	Estimated Universe Value
Chemistry	50	554,610	$10.6 million
Hematology	50	1,079,075	$14.9 million
Urinalysis	50	154,882	$0.9 million

The 150 instances were selected from a universe of payments in MSIS representing Medicaid claims reimbursed by the State Agency that contained more than one profile or a profile and individual tests for the same beneficiary on the same date of service by the same provider.

The MSIS payment amounts are estimates; the State Agency reports the amount allowed for each service included on a claim. We used the MSIS monetary information only to establish an initial estimate of the amount of possible unbundling and duplicate charges reimbursed by the State Agency. The MSIS estimates were considered adequate for this purpose. However, in determining our projections, we used the actual amounts paid by the State Agency for each service reviewed.

- Reviewed supporting documentation from the State Agency for each instance included in our random sample to determine the propriety of the payments.

- Used a variable sample appraisal methodology to estimate the payment amounts for unbundled or duplicate chemistry, hematology, and urinalysis tests.

See Attachment A to this report for a detailed discussion of our sample methodology.

Our review of internal controls was limited to an evaluation of that part of the claims processing function that related to the processing of claims for clinical laboratory services for chemistry, hematology, and urinalysis. Specifically, we reviewed State Agency: (1) policies and procedures, (2) instructions to providers, and (3) other documentation relating to manual and automated edits to detect unbundled and duplicate claims for chemistry, hematology, and urinalysis tests.

We found that the items tested were in compliance with applicable laws and regulations except for the matters discussed in the Detailed Results of Review section of this report. We performed our review between March and September 1995. During our review, we visited the State Agency offices in Sacramento, California, and discussed the results of our review with State Agency officials.

DETAILED RESULTS OF REVIEW

The State Agency had numerous edits in place to detect provider billings to Medicaid for laboratory services that were not properly bundled. Providers are required to combine specific laboratory tests into groups billed as a single item, often referred to as bundling. However, in our random sample of 150 instances of possible unbundled or duplicate charges for laboratory services, we found that 116 of these instances represented unbundled or duplicate charges.

Based on our review, we estimate that the unbundled or duplicate charges amounted to $8,026,980 (Federal share $4,01 3,490) for chemistry, hematology, and urinalysis tests for CYS 1993 and 1994.

	Items Tested	Examined Values	Number of Unbundled or Duplicate Items	Projected Amount of Unbundled or Duplicate Items	Federal Share
Chemistry	50	$957.16	34	$3,966,460	$1,983,230
Hematology	50	689.05	46	3,727,988	1,863,994
Urinalysis	50	293.50	36	332,532	166,266
Totals	150	$1,939.71	116	$8,026,980	$4,013,490

At the 90 percent confidence level, the estimated amount of duplicate or unbundled charges is between $6,939,666 and $9,114,294.

The 116 instances of unbundled or duplicate charges were reimbursed by the State Agency because it did not have edits to detect the following:

- unbundling of two chemistry tests,
- unbundling of CPK and GGT from chemistry profiles,
- unbundling of hepatic function panels from chemistry profiles,
- unbundling of bilirubin tests from chemistry profiles,
- separate billing of hematology indices from hematology profiles,
- separate billing for more than one hematology profile or a hematology profile and hematology test, and
- unbundling or separate billing of automated or unautomated urinalysis and/or urinalysis microscopy examination from the urinalysis with microscopy service.

CHEMISTRY TESTS

Our review of 50 instances involving claims containing possible unbundled charges for chemistry tests disclosed that there were 16 instances paid by the State Agency at reduced rates to reflect the bundling requirements and 34 instances of unbundled tests.

Our review of chemistry claims found:

- 2 instances where two chemistry tests were billed separately and not combined into an 80002 chemistry profile,
- 20 instances where the CPK (CPT code 82550) ardor GGT (CPT code 82977) chemistry tests were unbundled (both of the California carriers include these tests with the automated chemistries),
- 2 instances where bilirubin (82251) tests were unbundled,
- 8 instances where providers did not properly combine chemistry profiles and tests with the hepatic function panel (the hepatic function panel is made up of automated chemistry tests and should, therefore, be combined when billed with a chemistry profile or test), and

- 2 instances where the CPK and/or GGT chemistry tests were unbundled and where providers did not properly combine chemistry profiles and tests with the hepatic fiction panel.

Based on our statistical sample, we estimate that the State Agency overpaid providers $3,966,460 (Federal share $1,983,230) for unbundled chemistry profile tests for CYs 1993 and 1994.

HEMATOLOGY

Our review of 50 instances involving claims containing hematology profiles disclosed that 40 of these instances contained charges for indices and 6 contained charges for two profiles or a profile and a single test.

The State Agency did not have edits to detect instances where two similar hematology profiles were billed. There also were no edits to detect when a profile and a test which should be part of that profile were billed. Hematology tests are performed and billed in groups or combinations of tests known as profiles. The hematology tests are grouped into profiles of specific hematology tests; however, hematology tests can also be performed individually. Duplicate billings occur when individual hematology tests are billed for the same patient for the same date of service as a hematology profile which includes the individual test. Duplicate billings also occur when two hematology profiles are billed for the same patient and same date of service.

The State Agency did not have edits to detect instances where providers separately billed indices (CPT codes 85029 and 85030) with a profile code. Hematology indices are calculations and ratios calculated from the results of hematology tests. Because hematology indices are calculated along with the performance of each hematology profile, a separate billing for hematology indices on the same date of service results in a duplicate billing.

Based on our statistical sample, we estimate that the State Agency overpaid providers $3,727,988 (Federal share $1,863,994) for duplicated hematology tests for CYS 1993 and 1994.

URINALYSIS

Our review of 50 instances involving claims containing urinalysis tests disclosed that 36 of these instances involved urinalysis tests that were unbundled or duplicated for payment purposes.

A complete urinalysis includes testing for components and a microscopic examination; however, providers can perform and bill different levels of urinalysis testing. In this regard, they can perform a urinalysis with microscopic examination, a urinalysis without

microscopic examination, or a microscopic examination only. Based on the test performed and billed, unbundling or duplication of billing can occur among these tests.

The Medicare Carriers Manual section 5114.1 F states that if a urinalysis examination which does not include microscopy (CPT code 81002) and a urinalysis microscopy examination (CPT code 81015) are both billed, payment should be as though the combined service, urinalysis with microscopy (CPT code 81000), had been billed.

We found that the State Agency did not have edits to detect instances where providers:

- unbundled costs by not properly combining automated or unautomated urinalysis tests (CPT codes 81002 and 81003) with the urinalysis microscopy examination (CPT code 81015) and billing as a combined service (CPT code 81000), or

- duplicated charges by separately billing for either the urinalysis tests (CPT codes 81002 and 81003) or microscopy examination (CPT code 81015) with the combined service (CPT code 81000).

Based on our statistical sample, we estimate that the State Agency overpaid providers $332,532 (Federal share $166,266) for unbundled or duplicated urinalysis tests for CYS 1993 and 1994.

RECOMMENDATIONS

We recommend that the State Agency :

(1) Implement additional edits to detect and prevent payments for the following:

- not bundling two chemistry tests into an 80002 chemistry profile,

- unbundling of CPK (CPT code 82550) and GGT (CPT code 82977) chemistry tests from the chemistry profiles,

- unbundling of bilirubin (82251) tests from the chemistry profiles,

- separate billing of hepatic function panels (CPT code 80058) with chemistry profiles,

- separate billing of hematology indices (CPT codes 85029 and 85030) from hematology profiles,

- separate billing for more than one hematology profile or a hematology profile and hematology test, and

- unbundling or separate billing of automated or unautomated urinalysis (CPT codes 81002 and 81003) and/or urinalysis microscopy examination (CPT code 81015) from the urinalysis with microscopy service (CPT code 81000).

(2) Notify providers of proper billing procedures for the services identified in our audit.

(3) Identify and recover Medicaid overpayments from clinical laboratories for unbundled or duplicate services included in this review. Based on our audit, we estimate $8,026,980 (Federal share $4,013,490) should be recovered for CYS 1993 and 1994.

(4) Make adjustments for the Federal share of amounts recovered, if any, on the Quarterly Report of Expenditures submitted to HCFA.

STATE AGENCY COMMENTS AND OIG RESPONSE

In its response to our audit report, the State Agency expressed the opinion that it was not required to follow Medicare guidelines pertaining to laboratory procedures, including those Medicare carrier guidelines governing the unbundling of laboratory tests. According to the State Agency, it is guided by the published CPT codes and its own State regulations. The State Agency listed three examples of its disagreement with our specific findings. It stated that it has no plans to make any recoveries based on the report. The State Agency did, however, agree to research the points identified in the report to determine what opportunities were available for savings that were not currently being developed and/or implemented. The State Agency comments have been included as Attachment C-to this report.

We do not feel that the State Agency is correct in its opinion that it is not required to follow Medicare guidelines pertaining to unbundling. We also do not believe that the points of disagreement raised in the examples are valid. However, most importantly, the State Agency agreed to research the recommendations made in our report in order to identify future opportunities for cost savings. Included in the State Agency's response were three specific examples of "inaccurate information" with comments. We have responded to these three items in Attachment D to this report.

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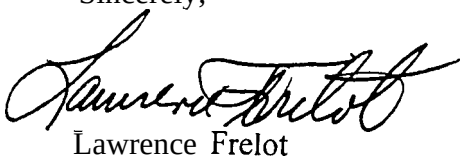
Please refer to Common Identification Number A-09-95-00072 in all correspondence relating to this report.

Sincerely,



Lawrence Frelot
Regional Inspector General
for Audit Services

Attachments

ATTACHMENTS

SAMPLE METHODOLOGY

From the HCFA Medicaid Statistical Information System (MSIS) paid claims file for the State of California for CYs 1993 and 1994, we used computer applications to extract all claims containing:

- Automated multichannel chemistry profile tests for chemistry procedure codes listed in the Physicians' CPT handbook.
- Hematology profiles and component tests normally included as part of a hematology profile for hematology procedure codes listed in the CPT handbook.
- Urinalysis tests and component tests listed in the CPT handbook.

See Attachment B for a listing of the CPT codes included in our review.

The above file extract yielded a total of approximately $109.5 million in payments for chemistry, hematology, and urinalysis tests in CYS 1993 and 1994. This total consisted of:

- Chemistry tests - 4,607,651 records totaling approximately $46.1 million,
- Hematology tests - 7,562,444 records totaling approximately $50.9 million, and
- Urinalysis tests - 3,032,237 records totaling approximately $ 12.5 million.

We then performed computer applications to extract all records for the same individual on the same date of service by the same provider with HCFA's Common Procedure Coding System (HCPCS) line-item charges for:

- More than one chemistry profile; a chemistry profile and at least one individual profile test; or two or more profile tests.
- More than one automated hematology profile under different profile codes; more than one unit of the same profile; a component normally included as part of a profile in addition to the profile; or hematology indices and a profile.
- More than one of the following tests: a complete urinalysis and microscopy; a urinalysis without microscopy; or a microscopic only.

The extract resulted in a sample population for the State Agency consisting of three strata.

Strata	Instances	Estimated Payments
Chemistry	554,610	$10.6 million
Hematology	1,079,075	14.9 million
Urinalysis	154,882	0.9 million
Totals	1,788,567	$26.4 million

Each instance is a potential payment error in which the State Agency paid providers for clinical laboratory tests (on behalf of the same beneficiary on the same date of service) which were billed individually instead of as part of a group, or were duplicative of each other.

During our review, we found that the amounts included in the MSIS are not reliable amounts when reviewed on a line-item basis. The State Agency does not provide the actual amount allowed for each claim by line item to the MSIS. Instead, a pro rata share of the total claim paid by the State Agency is distributed to each line within a claim to fairly distribute third-party recoveries.

The pro rata share is calculated using each line-item's submitted costs rather than the actual amount paid. The submitted costs for each line-item are divided by the total submitted costs to determine the line-item's percentage of the total submitted costs. This percentage is multiplied by the total amount paid for the claim by the State Agency to arrive at the amount reported in MSIS.

We used the MSIS monetary information only to establish an initial estimate of the amount of possible unbundling and duplicate charges reimbursed by the State Agency. The MSIS estimates were considered adequate for this purpose. In determining our projections, we used the actual amounts paid by the State Agency for each service reviewed.

The stratified random sample consisted of the following:

Sample Strata	Sample Size	Value
Chemistry	50	$ 957.16
Hematology	50	689.05
Urinalysis	50	293.50
Totals	150	$1,939.71

For the sample items, we reviewed supporting documentation from the State Agency consisting of copies of physician, hospital, or independent laboratory claims, electronic paid claims details for claims submitted electronically, explanations of benefits paid, and related paid claims histories.

We used a stratified variable appraisal to quantify charges for unbundled chemistry profile tests, duplicate hematology profile tests, and unbundled urinalysis tests as shown in the following schedule.

Strata	Number of Items	Items Tested	Examined Value	Number of Items Overpaid	Estimated Charges
Chemistry Tests	554,610	50	$957.16	34	$3,966,460
Hematology Tests	1,079,075	50	$689.05	46	$3,727,988
Urinalysis Tests	154,882	50	$293.50	36	$ 332,532
Overall	1,788,567	150	$1,939.71	116	$8,026,980

The results of the scientific sample of chemistry tests disclosed that 34 of 50 instances we reviewed represented unbundled chemistry profile tests. Projecting the results of the sample, we estimate that $3,966,460 was paid for unbundled chemistry profile tests.

The results of the scientific sample of hematology tests disclosed that 46 of 50 instances we reviewed represented duplicate hematology profiles and profile component tests. Projecting the results of the sample, we estimate that $3,727,988 was paid for duplicate payments for hematology profile tests.

The results of the scientific sample of urinalysis tests disclosed that 36 of 50 instances we reviewed represented unbundled and duplicate urinalysis tests. Projecting the results of the sample, we estimate that $332,532 was paid for unbundled and duplicate urinalysis tests.

The overall results of the scientific sample disclosed that 116 of 150 instances we reviewed represented unbundled or duplicate tests. Projecting the results of the sample, we estimate that $8,026,980 was paid for unbundled or duplicate tests. At the 90 percent confidence level, the estimated amount of duplicate or unbundled charges is between $6,939,666 and $9,114,294.

AUTOMATED MULTICHANNEL CHEMISTRY PROFILE TEST HCPCS

Chemistry Profile CPT Codes

80002 one or two clinical chemistry automated multichannel test(s)
80003 three clinical chemistry automated multichannel tests
80004 four clinical chemistry automated multichannel tests
80005 five clinical chemistry automated multichannel tests
80006 six clinical chemistry automated multichannel tests
80007 seven clinical chemistry automated multichannel tests
80008 eight clinical chemistry automated multichannel tests
80009 nine clinical chemistry automated multichannel tests
80010 ten clinical chemistry automated multichannel tests
80011 eleven clinical chemistry automated multichannel tests
80012 twelve clinical chemistry automated multichannel tests
80016 thirteen-sixteen clinical chemistry automated multichannel tests
80018 seventeen-eighteen clinical chemistry automated multichannel tests
80019 nineteen or more clinical chemistry automated multichannel tests
80050 General Health Panel
80058 Hepatic Function Panel

Chemistry Tests Subject to Profiling (34 CPT Codes)

1.	Albumin	82040
2.	Albumin/globulin ratio	84170
3.	Bilirubin Total OR Direct	82250
4.	Bilirubin Total AND Direct	82251
5.	Calcium	82310, 82315, 82320, 82325
6.	Carbon Dioxide Content	82374
7.	Chloride	82435
8.	Cholesterol	82465
9.	Creatinine	82565
10.	Globulin	82942
11.	Glucose	82947
12.	Lactate Dehydrogenase (LDH)	83610, 83615, 83620, 83624
13.	Alkaline Phosphatase	84075
14.	Phosphorus	84100
15.	Potassium	84132
16.	Total Protein	84155, 84160
17.	Sodium	84295
18.	Aspartate arninotransferase (AST, SGOT)	84450, 84455
19.	Alanine aminotransferase (ALT, SGPT)	84460,84465
20.	Urea Nitrogen (BUN)	84520

AUTOMATED HEMATOLOGY PROFILE & COMPONENT" TEST HCPCS

Chemistry Tests Subject to Profiling (34 CPT Codes) Continued

21. Uric Acid	84550
22. Triglycerides	84478
23. Creatine Kinase (CPK)	82550, 82555
24. Glutamyltransferase, gamma (GGT)	82977

Hematology Component Test CPT Codes

Red Blood Cell Count (RBC) only	85041
White Blood Cell Count (WBC) only	85048
Hemoglobin, Calorimetric (Hgb)	85018
Hematocrit (Hct)	85014
Manual Differential WBC count	85007
Platelet Count (Electronic Technique)	85595

Additional Hematology Component Tests - Indices

Automated Hemogram Indices (one to three)	85029
Automated Hemogram Indices (four or more)	85030

Hematology Profile CPT Codes

Hemogram (RBC, WBC, Hgb, Hct and Indices)	85021
Hemogram and Manual Differential	85022
Hemogram and Platelet and Manual Differential	85023
Hemogram and Platelet and Partial Automated Differential	85024
Hemogram and Platelet and Complete Automated Differential	8 5 0 2 5
Hemogram and Platelet	85027

URINALYSIS TESTS

Urinalysis	81000
Urinalysis without microscopy	81002, 81003
Urinalysis microscopic only	81015

STATE OF CALIFORNIA-HEALTH AND WELFARE AGENCY PETE WILSON, Governor

DEPARTMENT OF HEALTH SERVICES
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Mr Lawrence Frelot
Regional Inspector General
for Audit Services
Department of Health and Human Services
Office of inspector General
Region IX
Office of Audit Services
50 United Nations Plaza, Room 171
San Francisco, CA 94102

Dear Mr. Frelot:

Reference CIN: .4-09-95-00072

Thank you for providing the draft report presenting the results of your review of the California Department of Health Services' (Department) Medicaid program. Although dated November 21, 1995, the report was received by the Department on February 2, 19%. The report deals with reimbursemem of clinical laboratory services under the Medicaid program. The Department has reviewed the report and finds that it must disagree with the findings and recommendations, as they fail to consider many policy edits and regulations that were in place during and subsequent to the review period.

Additionally the fact that an audit report would result from the interview with the Office of Inspector General (OIG) representative was never made clear. As a result, the Department did not utilize standard audit protocols and resources for assisting in program audits. These resources would have assured that the auditor understood the complex system used in California to process Medicaid claims, thus avoiding some of the confusion reflected in the draft report

The report and its findings appear to be based on unpublished data extract procedures that do not reflect California's Code of Regulations (CCR), Title 22, or the Current Procedural Terminology (CPT) codes in place during the review period. The report cites HCFA State Medicaid Manual, Sections 6300 I and 6300.2, as a basis for the report audit exceptions. The Medicaid Manual sets forth guidelines pertaining to rates fur services. and the Department abides by those requirements. There is no regulation that requires the Department to usc the same edits and audits used by the Medicare carriers.

The Medicare carriers do not typically publish all of the edit/audits being used and, in fact. the practices from carrier to carrier throughout the United States are not consistent. Therefore, we are concerned about being measured against criteria we were unaware of, and believe are not applicable to the Medicaid program. At times, the Department finds it impractical and often cost prohibitive or ineffective to follow Medicare guidelines that sre available.

The Department checks and revises rates each year based on the average of the Medicare rates provided by the two California Medicare carriers. Although Medicare rate change.. are implemented each year on January 1, there is it lag period in which the Department can make changes. Usually. the Department receives rate change information from the two Medicare carriers sometime in December. The Department most rhen review these changes, make necessary revisions to regulations and the system (when applicable), and provide 30 days notice to providers. This process can take many months to complete. Ongoing coordination problems between Medicare and Medicaid at the Federal level further complicate the issue. This year, one of the carriers informed the Department that HCFA would be providing the rare change information. The Department did not receive the updated information from HCFA until February 13.1996. In instances where the Department does nnt receive timely information, research is done to determine what is published in Medicare bulletins and emporary changes are made based on that information At times, the information *in the* Medicare bulletins does not reflect Lhe same information that comes from the carriers or HCFA. The Department must then make any necessary corrections. In any event, the Department dots not pay more than the Medicare amounts in place on the dates of service on claims, and in general. the Department pays less than the Medicare allowable

The Department uses CPT codes as a guideline when establishing the policies pertaining to laboratory procedures The lists of procedures used for the review arc not reflective 01' the published CPT codes. As previously stated, the codes used appear to be based on unpublished. internal Medicare carrier edits and audits Examples of where *the* review uses inaccurate information follow:

- Finding: The Department does not have edits to detect the unbundling of two chemistry tests (CPT Code 80002).

- Response: This code is not it Medi-Cal program benefit and is addressed in CCR, Title 2'2 Section 51529. If it were to become a program benefit, regulation amendments would he required.

- Finding: The Department dews not have edits to detect the unbundling of Creatine Phosphokinase (CPK) and Gamma Glutamyltransferase (GGT) tests from chemistry panels

- Response. CPK and GGT are not part of the tests *included* in Title 22, or the CPT multichannel test list and are, therefore, billed with their individual procedure codes. The guidelines referenced its the review are from a procedure manual (an internal, confidential manual) of one of the Medicare carriers, and not from CPT.

- Finding The Department does not have edits to detect the unbundling of hepatic function panels from chemistry panels.

- Response: In 1993, The Department revised error codes 1365 and 1366 to comply with the CPT definition of the hepatic panel. If these codes are billed separately, the system will combine them and pay at the panel rate.

The Department, with its fiscal intermediary (Electronic Data Systems Corporation), is continually striving to implement cost savings measures by adding edits and audits that can detect instances of unbundling of services. The Department will research the points identified in the draft report to determine if there may he other opportunities for savings that are not currently being developed and/or implemented. However, at this time we do not plan to adjust any previously paid claims or refund HCFA tmy funds based on the findings of the draft report.

Your concern regarding California's Medicaid program is appreciated. If there are any questions or concerns, please feel free to contact Mr. Stan Rosenstein, Chief, Payment Systems Division at (9 I 6) 322-7598.

Sincerely,

John Rodriguez
Deputy Director
Medical Care Services

SELECTED STATE AGENCY COMMENTS WITH OIG RESPONSE

Included in the State Agency's response were three specific examples of "inaccurate information" with comments. We have included those here with OIG response to the three specific comments. These are intended to clarify misunderstandings about the —. recommendations.

State Agency Comments:

Finding: The Department does not have edits to detect the unbundling of two chemistry tests (CPT Code 80002).

Response: This code is not a Medi-Cal program benefit and is addressed in CCR, Title 22, Section 51529. If it were to become a program benefit, regulation amendments would be required.

OIG Response:

The CPT code 80002 is simply one of the multiple codes which represent the multiple chemistry tests. The code has been in the CPT listing at least since 1988 with fee schedule prices set by the carriers. The opening comments to this section indicated that the State Agency used the CPT as a guideline to set the policy for laboratory procedures.

State Agency Comments:

Finding: The Department does not have edits to detect the unbundling of Creatine Phosphokinase (CPK) and Gamma Glutarnyltransferase (GGT) tests from chemistry panels.

Response: CPK and GGT are not part of the tests included in Title 22 or the CPT multichannel test list and are, therefore, billed with their individual procedure codes. The guidelines referenced in the review are from a procedure manual (an internal, confidential manual) of one of the Medicare carriers, and not from CPT.

OIG Response:

The two carriers in California have both added three tests to the CPT standard list of chemistry tests, CPK, GGT, and Triglycerides. The State Agency has added Triglycerides to the list of chemistry tests used by California but not added the other two tests. The State Agency is indicating that it does not have to because the two tests are not on the CPT list. However, the State Agency did add Triglycerides even though it was not on the CPT list. Both of the carriers in California have repeatedly published the list of chemistry tests in the Medicare Bulletins that they send to all

providers in the State as well as to the State Agency. The State Agency even admits in the response using the Bulletins to get the fee schedule information. These are hardly internal, confidential manuals. In addition, HCFA has made changes to the Medicare program effective March 1, 1996, that add the three tests to the chemistry list for Medicare. This mandates the addition of the three tests for the Medicaid program since Medicaid cannot pay more for the tests than Medicare would allow.

State Agency Comments:

Finding: The Department does not have edits to detect the unbundling of hepatic function panels from chemistry panels.

Response: In 1993, the Department revised error codes 1365 and 1366 to comply with the CPT definition of the hepatic panel. If these codes are billed separately, the system will combine them and pay at the panel rate.

OIG Response:

The hepatic function panel is made up of chemistry panel tests. Therefore, it should be combined with any chemistry panel billed on the same day. It should only be allowed when there are no other chemistry tests on the same date of service.